Hearing Protection Requirement Waiver

Name: _____ DOB: _____

I, _____, have been informed that it is recommended to wear ear plugs during TMS therapy treatment to protect my hearing. Should I choose to refrain from wearing hearing protection, I understand and agree to hold harmless, MindBliss Psychiatry, its employees, physicians, affiliates, and agents in the rare event that my transcranial magnetic stimulation (TMS therapy) treatment has any impact on my hearing (due to my decision). I understand that it is my choice to not wear hearing protection and I must sign this waiver whether I choose to wear or decline ear plugs or ear protection.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date